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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EBONY NICOLE YATES** **3200 Lenox Road #F114** **Atlanta, GA 30324** **Registered Nurse License No. 580757** Respondent.	Case No. 2010-78 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN, ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about May 14, 2001, the Board issued Registered Nurse License Number 580757 to Ebony Nicole Yates ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2011, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

5. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

6. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 . . .

7. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

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8. Health and Safety Code section 11173 states, in pertinent part:

> (a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .

9. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

11. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

12. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 500 mg acetaminophen per tablet, and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

13. "Restoril", a brand of temazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(29).

14. "Percocet", a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

15. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

16. "Marijuana" is a Schedule I controlled substance as designated by Health and Safety Code section 11054, subdivision (d)(13).

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DAVID GRANT USAF MEDICAL CENTER

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about July 30, 2006, while employed as a registered nurse in the Inpatient Surgical Unit (hereinafter "unit") at David Grant USAF Medical Center, Travis Air Force Base, California, Respondent committed acts constituting gross negligence in her care of a patient as defined in Regulation 1442, as follows:

a. Respondent failed to conduct an assessment, or thorough assessment, of the patient upon his admission to the unit from the ER.

b. Respondent made false entries in the patient's medical records, as follows: Respondent copied information from the ER records into her nursing notes and prepared her nursing notes based on the ER records rather than her personal assessment of the patient.

c. Respondent made false statements to her supervisor, as follows: When confronted by the charge nurse on duty regarding her failure to assess the patient, Respondent represented to the charge nurse that she had, in fact, completed the assessment, then later stated that she had possibly conducted the assessment on another patient.

JOHN MUIR MEDICAL CENTER

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on and between January 27, 2007, and February 10, 2007, while working as a registered nurse at John Muir Medical Center, Concord, California, Respondent committed acts constituting gross negligence as defined in Regulation 1442, as follows:

Incident #1, Patient #4:

a. On or about January 27, 2007, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's and patient's records, as follows: At 01:47

hours, Respondent removed morphine 2 mg from the Pyxis for the patient, yet charted on the patient's medical administration record ("MAR") that she administered the morphine to the patient at 01:45 hours. Further, Respondent documented in the Pyxis that the removal was canceled at 03:19 hours.

Incident #2, Patient #5:

b. On or about February 5, 2007, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's and patient's records, as follows: At 05:56 hours, Respondent removed 1 Vicodin tablet from the Pyxis for the patient, yet charted on the patient's MAR that she administered the Vicodin to the patient at 05:52 hours.

c. On or about February 5, 2007, Respondent failed to perform an assessment, or reassessment, of the patient prior to administering the Vicodin.

Incident #3, Patient # 2:

d. On or about February 5, 2007, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's and patient's records, as follows: At 00:16 hours, Respondent removed 1 capsule of Restoril from the Pyxis for the patient, documented in the Pyxis that the removal was canceled at 00:16 hours, yet charted on the patient's MAR that she administered the Restoril to the patient at 00:13 hours.

Incident #4, Patient #1:

e. On or about February 9, 2007, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's and patient's records, as follows:

1. At 01:30 hours, Respondent removed 2 tablets of hydrocodone from the Pyxis for the patient, charted on the patient's MAR that she administered the medication to the patient at 01:30 hours, yet documented in the Pyxis that the 2 tablets of hydrocodone were returned "to bin" at 03:39 hours.

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2. At 03:33 hours, Respondent removed 2 tablets of oxycodone from the Pyxis for the patient and charted on the patient's MAR that she administered the medication to the patient at 04:09 hours (the physician's order called for the administration of 1 to 2 tablets of oxycodone every 4 hours as needed). At 04:11 hours, Respondent removed 2 additional tablets of oxycodone from the Pyxis for the patient, but failed to chart the administration or wastage of the medication on the patient's MAR or otherwise account for the disposition of the 2 tablets of oxycodone.

Incident #5, Patient #3:

f. On or about February 10, 2007, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's and patient's records, as follows:

1. At 02:48 hours, Respondent removed 1 tablet of Percocet from the Pyxis for the patient, documented in the Pyxis that the withdrawal was canceled at 02:48 hours, but charted on the patient's MAR that she administered the Percocet to the patient at 02:45 hours.

2. At 07:02 hours, Respondent removed 1 Percocet tablet from the Pyxis for the patient, but charted on the patient's MAR that she administered the Percocet to the patient at 07:01 hours.

3. At 01:40 hours, Respondent removed 1 tablet of Dilaudid from the Pyxis for the patient, but charted on the patient's MAR that she administered the Dilaudud to the patient at 01:36 hours.

4. At 06:22 hours, Respondent removed 1 tablet of Dilaudid from the Pyxis for the patient, but charted on the patient's MAR that she administered the Dilaudid to the patient at 06:19 hours.

THIRD CAUSE FOR DISCIPLINE

(Diversion, Possession, and Self-Administration of Controlled Substances)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,

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subdivision (a), in that on or about February 9, 2007, and June 24, 2008, while licensed as a registered nurse, Respondent did the following:

Diversion of a Controlled Substance:

a. Respondent obtained the controlled substance oxycodone by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: On or about February 9, 2007, between 03:33 and 04:11 hours, Respondent removed a total of 4 tablets of oxycodone from the Pyxis for Patient #1 when, in fact, the physician's order called for the administration of 1 to 2 tablets of the medication every 4 hours as needed. Further, Respondent charted on the patient's MAR that she administered 2 tablets of the medication to the patient at 04:09 hours, but failed to document the administration or wastage and otherwise account for the disposition of the remaining 2 tablets of oxycodone.

Possession of a Controlled Substance:

b. On or about February 9, 2007, Respondent possessed the controlled substance oxycodone, as set forth in subparagraph (a) above, without a valid prescription from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

Self-Administration of a Controlled Substance:

c. Respondent self-administered the controlled substance marijuana without lawful authority therefor, as follows: On or about June 24, 2008, Respondent provided an investigator with the Division of Investigation, Department of Consumer Affairs, with a urine specimen for drug testing. Respondent told the investigator that she might test positive for marijuana because she had smoked some about a week ago at a "going away" party for a friend. Respondent's urine specimen did, in fact, test positive for marijuana.

FOURTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that while working as a registered nurse at John Muir Medical Center,

Concord, California, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the medical center or patient records pertaining to patient assessment and to the controlled substances morphine, Vicodin/hydrocodone, Restoril, Percocet/oxycodone, and Dilaudid, as set forth in paragraphs 17 and 18 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 580757, issued to Ebony Nicole Yates;

2. Ordering Ebony Nicole Yates to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/11/09

Louise R. Bailey, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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